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Special Article

The Opinions and Actions of Physicians During a Malpractice Insurance Crisis

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THE TERM "CRISIS" is used frequently in discussions of health care in the United States. Fortunately, the labeling of all problems in the medical care sector as crises represents an exaggeration. Most are either crises in the eyes of the beholders, or represent acute reactions to the discovery of long-term chronic problems. Early 1976, however, was at the very least "a crucial time" for the medical profession in California and for the state as a whole as a result of a sizable increase in the premiums for malpractice insurance.

This "malpractice insurance crisis," like most others, had been brewing for many years. In fact, a similar acute episode of lesser magnitude occurred in 1975 when large premium increases were threatened. Mobilization of physicians to fight rising insurance costs was stifled in 1975 by political-legislative actions that provided short-term, symptomatic relief.

Late in 1975, however, physicians were notified by the various insurance carriers that either they would no longer be able to provide malpractice coverage, or that they would increase premiums. In the face of either cancellations or sharp increases in the costs of coverage, individually and collectively physicians undertook a variety of actions to cope with the problem. Some of these were on the drawing boards since 1975. Petitions were circulated, committees were formed and political action groups were organized; in brief, the malpractice problem became a highly visible public issue. Despite these activities, there was no change in the position of the insurance carriers, and it became evident that January 1976 would bring a significant increase in the cost of coverage to practitioners throughout California.

As this deadline approached, there was a pronounced acceleration and intensification of the behavioral manifestations of concern by the medical profession. In addition to the somewhat benign activities of petition-signing and making statements to the press, actual closing of practices occurred, with a reduction in the volume of physicians' services available. The number of elective surgical procedures carried out, for example, dropped off to a notable degree (according to surveys conducted from December 1975 through February 1976 by *The Los Angeles Times).*

As evidence of an impending shortage of patient-care services increased, we decided to identify systematically the opinions held and the activities undertaken in response to the "malpractice insurance crisis" by practicing physicians in Los Angeles County. This study was timed so that interviews with physicians would cluster around the deadline for the payment of new premiums (January 28, 1976). In this paper, we present a summary of the results of the survey.

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The Study Group

A random sample of 499 practicing physicians in Los Angeles County was drawn from the 1975-1976 directory of the Los Angeles County Medical Association. Table 1 lists the percentage of the practitioners by specialty included in the sample, compared with their relative distribution in the population of physicians within the county.

Letters were mailed to these physicians in advance to provide opportunity for informed consent when they were contacted. Telephone interviews were scheduled to span the period from January 25 to February 29, 1976. These were conducted by staff at the Survey Research Center of the Institute for Social Science Research, University of California, Los Angeles.

Of the 499 physicians in the sample, 12 percent (62) were no longer in practice at the time of the first telephone call. Except for three who had moved from the county, the rest had retired, or had discontinued their telephone service. Of the remaining 437, 68 percent (296) participated in the survey. Both the reasonably high response rate and the interest in the subject matter during the interview are indicators of the saliency of the subject to Los Angeles County doctors. In fact, some physicians who received letters describing the study called the Survey Research Center on their own initiative to make appointments for interviews.

Of the physicians from whom information was collected, slightly more than a fourth (26 percent) were interviewed before the deadline for paying the premium. There is no evidence of significant differences in the backgrounds of physicians or the information obtained from them among those interviewed before or after the deadline. Of the respondents, 93 percent were men. The median age was 51 years, 84 percent were white and the sample was geographically distributed, representing 118 zip code areas in the county.

Half of the study group had been in practice 20 years; 63 percent were board certified and 20 percent were board eligible. About 56 percent of the practitioners were in solo practice, 15 per-

TABLE 1.—*Specialty of Physicians Sample and County Distribution by Percent**

Specialty	*Sample N=296*	*Los Angeles County N=11,032*
General Practice	24.0	21.7
Internal Medicine/Cardiology	16.2	19.7
Surgery/Urology/Orthopedics/ Ophthalmology	23.3	19.5
Pediatrics	5.1	6.5
Obstetrics/Gynecology	8.4	7.3
Psychiatry	5.1	8.8
Radiology	3.7	5.0
Anesthesiology	4.7	4.4
Dermatology/Ear/Nose/Throat	4.1	3.6
Other	5.4	3.5

*County of Los Angeles Department of Health Services Planning and Budgeting Data Book, 1975.

TABLE 2.—*Actions Personally Participated in During the Crises by Age**

	PERCENT ACTIVE				
Type of Action	*30-39 N=32*	*40-49 N=95*	*50-59 N=96*	*60+ N=73*	*Total N=296*
Slowdowns	56.2	42.1	57.2	41.1	48.6
Letter Writing	62.5	51.5	55.2	43.8	52.4
Signed Petitions	62.5	53.6	68.7	47.9	58.4
Joined Committees and Groups	28.1	38.9	32.3	15.0	29.7

*Percentages total to more than 100 percent due to multiple responses.

TABLE 3.—*Plans for Future Practice*

Action	*Percent*
Practice as usual	51.5
Restrict practice	37.5
Stop practice completely	3.7
Increase fees	3.3
Stop until action taken	2.0
Move from California	1.0
Take a position where someone else pays for coverage	1.0

TABLE 4.—*Insurance Coverage and Practice Plans*

	INSURANCE COVERAGE (Percent)	
Practice Plans	*Plan to Carry in 1976 N=81*	*Not plan to carry in 1976 N=41*
Stop practice	9.9	19.5
Move practice	3.7	7.3
Restrict practice	86.4	73.2

TABLE 5.—*Plan to Carry Malpractice Insurance in 1976 by Specialty*

Specialty	*N=277*	*Percent who do not plan to carry malpractice insurance in 1976*
General Practice	67	26.9
Internal Medicine/Cardiology	46	10.9
Surgery/Urology/Orthopedics/ Ophthalmology/Neurology	61	37.7
Pediatrics	15	13.3
Obstetrics/Gynecology	23	52.2
Psychiatry	15	6.7
Radiology	11	18.2
Anesthesiology	12	33.3
Dermatology/Ear/Nose/Throat	11	27.3
Other	16	18.8

cent belonged to partnerships and 13 percent were practicing members of specialty groups. The median number of patients seen by these physicians was 85 per week, and one of eight patients seen was a Medi-Cal beneficiary. Only 10 percent of the physicians interviewed did not see Medi-Cal recipients. Some 25 percent of the patients of practitioners in this study were over 65 years of age.

Impact of Rate Increase

While more than 96 percent of the physicians were covered in 1975, only about 70 percent planned coverage for 1976 (all of this group reported they had paid the new premium at the time of the survey). This is reasonably similar to estimates that 75 to 80 percent of physicians had arranged coverage as reported in surveys conducted by the *Los Angeles Times* (February 4 and 5, 1976). Another 5 to 6 percent were undecided about coverage at the time of the survey. For the group who took out insurance, the median costs rose from $3,600 in 1975 to $8,000 in 1976.

Although most practitioners acquiesced and paid the much higher premiums, the typical physician in the county was an active opponent to the increase in premiums. Approximately half of the doctors were participants in slow-downs, letter writing and petition-signing and about a third joined one of several action groups formed in the county and state. As shown in Table 2, with the exception of joining such groups, a rarer action for practitioners over 60 years of age, there was participation by all age groups in actions opposing the increase. Moreover, neither years of practice, specialty nor other professional characteristics, including income, were systematically related to standing up to the carriers. Clearly the opposition was not limited to the younger generation.

The increased premiums affected practitioners' future plans. As shown in Table 3, only slightly more than half of the study group planned to practice as usual; more than a third intended to restrict practice by diagnosis, services provided or social characteristics of patients. If plans were realized, and the practitioners who planned to stop practice completely or move from the state actually took these actions, Los Angeles County will have had 5 percent fewer physicians in 1976 than in 1975.

As shown in Table 4, among the physicians who planned to change their practice as a response to the crisis, those taking the decisive actions of either stopping practice or moving were most likely to plan to not renew insurance. Some who planned to be insured are also in these categories, perhaps as a temporary protection until they make their long-term plans.

There were systematic differences by specialty regarding plans to carry insurance in 1976. As shown in Table 5, physicians who are either general surgeons or in practicing specialties such as obstetrics and gynecology, urology, ophthalmology and orthopedics were least likely to contemplate insurance coverage. In contrast, radiologists, internists and cardiologists more often paid the increased premiums.

There were also some differences in the social characteristics of insured and uninsured doctors, at least as they report about their plans. Plans to

TABLE 6.—*Perceived Impact of Crisis by Specialty on Income, Office Management, Public Opinion of Physician and Expected Morbidity*

		PERCENT REPORTING			
Specialty	*N**	*Some or great effect on income*	*Some or great effect on office management*	*Some or great effect on public opinion of physician*	*Expected increased morbidity*
General Practice	68	83.6	57.3	59.7	27.9
Internal Medicine/Cardiology	48	83.3	50.0	68.1	22.2
Surgery/Urology/Orthopedics/ Ophthalmology/Neurology	68	78.2	50.0	59.7	20.6
Pediatrics	15	57.1	6.7	53.8	7.7
Obstetrics/Gynecology	25	88.0	70.8	66.6	12.0
Psychiatry	15	50.0	33.3	80.0	40.0
Radiology	11	90.9	70.0	88.9	36.4
Anesthesiology	14	78.6	50.0	83.3	28.6
Dermatology/Ear/Nose/Throat	12	83.3	58.3	66.6	33.3
Other	16	80.0	21.4	62.6	25.0

*The sample numbers varied slightly from variable to variable because of occasional missing data.

practice "uncovered" were most common among those in the 40 to 49 age group and of physicians with incomes of less than $50,000 per year.

Opinions on Crisis

The physicians interviewed were asked to project the consequences of the insurance crisis on their income, the management of their office, and the public. As shown in Table 6, they clearly saw the increased premiums as affecting their incomes, with some 80 percent reporting negative impact. A large proportion, consistent with the finding that many doctors would restrict their practices, reported that the ways they managed their offices would be modified. Moreover, more than 70 percent felt it would have at least some impact on the public's conception of the medical practitioner, and many believed it would increase morbidity. These data are shown by practice specialty, with most of the differences explainable by the type of practice of physicians in the study group.

The survey also included items on who was to blame for the higher premiums and how to deal with the rising insurance costs (see Tables 7 and 8). The diagnosis and prescription are consistent: lawyers and the legal system were indicted most frequently. Almost half would restrict lawyers' fees in malpractice cases; more than a fourth would eliminate jury trials. Only one of eight believed improved doctor-patient relations would make a difference and less than 4 percent thought stricter peer review procedures were a remedy.

In view of the fact that a good deal of action on the legislative front had been concerned with the creation of doctor-controlled insurance carriers, it was of interest that only 2.4 percent believed that this was the most effective way of dealing with this dilemma. Doctors feel the malpractice crisis is exogenous to the medical care system and that the cure lies outside it as well.

TABLE 7.—*Responsibility for the Higher Insurance Premiums**

Groups Blamed	*Percent Believing Responsible N=296*
Lawyers	82.1
Insurance companies	53.0
Public	34.8
Government	29.7
Some other group	20.9
Doctors	20.3
No one to blame	1.4

*Percentages total to more than 100 percent due to multiple responses.

TABLE 8.—*Ways to Reduce Fees*

Ways to Reduce Rates	*Percent Believing Most Effective N=296*
Restrict lawyer fees	46.6
Eliminate jury trials	27.4
Improve impersonal relations	12.2
More peer review	3.7
Physician control insurance	2.4
Real informed consent	0.7
Stricter regulations	0.7

Discussion

As of the summer of 1976, the crisis seemed to have subsided—the problem once again became subclinical. A significant proportion of physicians, however, apparently, have elected not to carry malpractice insurance. Those "uncovered" are overrepresented by younger physicians in early and less remunerative stages of their practice careers, and those who are at high risk and have substantial premiums to pay. Some physicians, perhaps as many as 5 percent of the county's practitioners, may no longer be providing direct care services (this is currently being examined by our staff).

The data on the study group—age, sex, nature of practice, types of patients—are reasonably consistent with the general data on physicians in this area, suggesting that the sample was fairly representative of practicing physicians as a group. The opinions held by these physicians about the causes of the problems and the proposed treatment are consistent with most statements by physicians that have appeared in the press and news media.

Although the size of the sample and the information at hand do not allow for a full unraveling of the determinants of electing coverage, physicians were faced with the decision of could they or would they pay the increased costs of coverage. For some, personal opposition to the imposed increase and its perceived implications may have been the principal determinant. For others, the question was undoubtedly whether or not they could afford their premiums. Some who felt they could not increase their gross income —because of their length of time in practice, their specialty or the ability of their patients to pay increased fees—may have been unable, if not unwilling, to pay the insurance premiums.

For physicians in certain specialties, the sheer amount of the insurance may have been the key factor in not electing coverage. For some,

the premium approaches $40,000 per year, and a personal illness of one month would cause severe financial problems for a person in solo practice whose other expenses would continue during such an illness. Also, for some physicians in "high-risk" specialties, the combination of reducing total liability by having minimum assets in his or her own name that can be garnered in case of a large judgment, and a "self-insurance" investment program may seem to be a better option than the high premiums. Both practice and social characteristics of physicians in relation to their decision to elect insurance is an area that merits further study.

Summary

The chronic malpractice insurance crisis in California, indeed in the United States, has not been resolved. In this state, it has temporarily regressed to a tolerable level for physicians. As costs continue to escalate, and in all probability they will, by the next anniversary for payment of premiums the phenomenon may once again be repeated. In view of the notorious lack of efficacy of most of the actions taken in 1976, it will be of interest to examine future activities of physicians to see if actions of a different nature are advocated.

While malpractice is certainly affected by certain legal practices, many see it occurring as a result of a complex interplay of factors involving public expectations and physician negligence as well as the tort system. Concern with the physician's role in the malpractice insurance crisis was noticeably absent from the responses of those in the survey. While some acknowledged that public expectations of cure without consequences contribute to this problem, few advocated interventions based on dealing with patients *and* physicians in treating this systematic disorder that threatens the health of the health care system in the United States.

A New Approach to Episiotomies

Most of our episiotomies today are done in the midline. If you would like to extend your episiotomy, but feel that you've gone as far as you dare vaginally and do not wish to incise the rectal sphincter . . . put a bleb of novocain at about 2 o'clock and about 10 o'clock in the hymenal ring. Make small incisions in the hymen (they do not have to extend more than approximately one centimeter) and you will be surprised at the increase in the circumference that occurs at the hymenal margin which, in turn, will benefit you insofar as being able to deliver the child without incurring a laceration or an extension of the episiotomy.

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